risk of infection; then the complete Listerian dressing is the proper one to adopt.

I will next speak of large flesh-wounds, wounds involving joints and other cavities, and wounds involving bone, such as amputations. These may be all classed together, for one treatment is adapted to all. I am not aware of any treatment which will, in the majority of cases of this class, secure primary union; nor do I think it is likely that any such will ever be discovered. No doubt it occasionally occurs under various methods of dressing; but where there is considerable oozing, which cannot be completely stopped, where muscle is no longer in contact with muscle, tendon with tendon, or subcutaneous fat with fat, but each in apposition to tissue of another kind, it does not seem likely that primary union will ever be the rule. In all cases of this class, I regard asepticism, in its most exact signification, as involving least risk to life, and as most favouring local cure, of any method of treatment with which we are acquainted. No method of maintaining asepticism equals the carbolic gauze dressing, with all the adjuncts of spray, carbolic lotion, etc. I have tried, or seen tried, a great variety of other dressings avowedly antiseptic; but no other as yet seems worthy of holding a permanent place. I have no doubt that a better will be discovered. Its disadvantages are obvious enough. It is troublesome, cumbrous, somewhat irritant, and, above all, it keeps the wound sodden; and this unquestionably is not the most favourable condition for healing. But its certainty—the fact that it *will* do what we intend unflinchingly, where the conditions are at our command, and we make no mistakes—places it above everything else yet brought forward. The drainage-tube is too essential a point of this dressing to be passed over without a word; it provides a ready channel for the escape of discharges, and prevents distension. Drainage should be limited to as few lines as possible, so that the surfaces may be kept thoroughly in contact.

Only one set of incised wounds remains, where the wounds are connected with suppuration already existing, as in opening an abscess, excising a suppurating joint, or removing dead bone. Unless the whole surface which discharged pus can be removed, such wounds may be expected to continue suppurating. In these, also, complete asepticism should be secured whenever possible; but, in a great many, from the impossibility of reaching every corner where putrefaction dwells, it cannot be attained, and I believe we then do best by using some efficient unirritating antiseptic, such as carbolised oil (one to twelve), applied on lint, and frequently renewed. In this class, I find myself yearly using the drainage-tube less and less, preferring, in a great majority of cases, to make a large wound, and leave it fully open. If the case be one where there is a reasonable probability of securing complete freedom from putrefaction, I put a plug of carbolised gauze in the wound, and an ordinary gauze dressing over it. If it seem hopeless to expect an antiseptic condition, I plug the wound with lint, soaked in carbolised oil, and have it frequently changed. Excisions of joints, as of the elbow and hip, I now treat in this way, and have got better results than when sutures were used. There is no possibility of discharge being retained; the wound heals uniformly from the bottom, no pockets of pus or sinuses remain; I believe healing is more rapid. I showed you at last meeting a case of excision of the elbow, for suppurating in the joint and sinuses communicating externally, which was absolutely healed in five weeks and four days after the operation. These remarks apply also to cases in which a cavity, that the tissues will not fill, remains after an operation. It is better to leave such a cavity open, than to shut it up by pulling skin over it.

I now come to contused wounds. When these approximate the characters of incised wounds, as so often happens with the scalp, the edges being sharp and clean, with little damage to the tissues around, they should be treated as incised wounds. The results are often surprisingly good. Large, irregular, branching wounds, caused by a blow from some blunt instrument, or a fall, often heal without any formation of pus. If these are at one end of the scale of contused wounds, at the other are cases where there is no doubt that the vitality of the injured part is for ever destroyed, and that amputation is our only resource. As this brings them into the class of incised wounds, they call for no further remark. But there is an intermediate class, where the amount of injury is doubtful, and where only time can show whether the tissues can live or not—cases, I may say, often of great responsibility and great anxiety. Such injuries, if seen early, should have antiseptic measures put in force at once. To be successful, they should be done very early, as everything in the condition of the wound favours the speedy advent of putrefaction. Very many cases so treated will well repay the trouble. I have seen apparently hopelessly damaged tissue retain its vitality, and I have seen sloughs slowly absorbed without constitutional disturbance or infective sequelæ. When a contused wound of this kind becomes putrid, I generally have it dressed with carbolised oil or charcoal poultices until the sloughs are mapped out, and then re-

move these as speedily as possible. I do not think too much importance can be attached to this, for dead and putrifying tissue forms a terribly active centre of constitutional contamination. Continuous irrigation with carbolic lotion or Condy's fluid, gives often good results with this kind of injury, specially where efficient treatment has not been instituted at once, and where widespread putrid suppuration is going on. It washes away the discharge as it is formed, and by its mechanical, as well as by its antiseptic action, it tends to keep such a wound sweet.

Punctured wounds do not call for much comment. They bear a small proportion to the other classes in civil practice. Their importance depends very much on the tissues or organs they involve, and it would be beyond the scope of these remarks to go into details. Small punctured wounds heal readily with rest alone. For medium-sized ones, an ice-bag is a useful application, the larger ones should be treated antiseptically.

In conclusion, I purpose making a few remarks on the principles and objects we have to keep in view in treating recent wounds. First in importance is the avoidance of constitutional infection; and, second, the speedy healing of the wound, and the restoration of the part to usefulness. These are not synonymous for a treatment which, if successful, results in speedy healing, but may, nevertheless, involve great risk of general infection in the event of its failure, such as the dry treatment of large wounds. I think it is our duty always to keep before us the gravity of the constitutional risk, and to consider first what reduces this to its lowest point, and to regard local recovery as an important but still secondary matter. If we inject a putrid fluid into an animal, we can get exactly the disease which used to afflict our surgical wards, and the evidence is very conclusive that the poison which produces grave general risk, is inseparably connected with putrefaction. Any one who goes over the experiments of Pasteur, of Lister, of Roberts, or of Tyndall, can, I think, come to only one conclusion, that putrefaction invariably originates in infection from without. But it needs a suitable soil, a certain amount of moisture and heat. Various substances are prone to it in various degrees, living tissues much less than dead ones, healthy much less than unhealthy, thick fluids much less than thin. We may, therefore, endeavour to carry out an antiseptic treatment from two opposite directions. We may either make the soil a very unsuitable one, as in the dry treatment, or we may prevent the access of septic material, as by the Listerian dressing. Experience and science alike tell us that, while we look after the wounds, we must not forget the body in which they are, and that pure air, good food, and careful nursing are not less essential than lotions, and sutures, and dressings.

GELSEMINUM SEMPERVIRENS IN TETANUS.

By JOHN B. READ, M.D., Tuscaloosa, Alabama.

[DEAR SIR,—Two years ago, my friend and kinsman, Dr. John B. Read of Tuscaloosa, Alabama, sent me the enclosed report of a case of tetanus cured by gelseminum extract, with the request to publish it in some New York Medical Journal. The report was mislaid, and came to light only a few days ago. I think it of much importance, and hope you will find a corner for it in the BRITISH MEDICAL JOURNAL, and oblige, yours truly,

J. MARION SIMS.

December 2nd, 1882.

The above letter has been forwarded to us by Dr. Marion Sims, with the following report.]

Early in September 1880, I was called to see a strong, healthy mulatto woman, twenty years old, who was suffering from well marked tetanic convulsions, caused by a broken bit of glass, on which she had trodden two days previously, and which was embedded in her heel.

I administered chloroform to enlarge the wound and search for the broken glass. It was impossible to anesthetise her profoundly, and her foot was forcibly held by strong assistants while I made free incisions, but failed to find the fragment of glass. The wound was then filled with morphia, and a common poultice applied; and a cathartic was given, which acted promptly.

Knowing well the inefficiency of chloroform, chloral, and opiates in tetanus, I determined to try the effect of the gelseminum sempervirens, because of its well known power of relaxing all voluntary muscles. I therefore ordered twenty minims of fluid extract of gelseminum every two hours, alternating with the same quantity of liquor potassæ at the same intervals. There was great difficulty in deglutition; but milk and soups were taken in small quantities frequently.

On the morning of the second day, there was a slight improvement in the rigidity of the jaw, and the general spasms occurred only every three or four hours. But, as the day advanced, the jaw became more

rigid, and there were violent and painful contractions of the muscles on the front and back of the chest. The general spasms also became more frequent, and sometimes occurred during sleep.

The dose of gelseminum extract was then increased to forty minims every two hours. During the third day, there was a marked improvement in both tonic and clonic spasms; the medicine was continued in forty-minim doses. By the close of the fourth day, the rigidity of the jaws was almost entirely relieved, and the general spasms recurred at longer intervals, and with diminished violence. After this period, the improvement was rapid and regular, and the dose of gelseminum was reduced to twenty minims, at which it was continued till full convalescence. No remedy of any potency was used after the first six hours but the gelseminum, and there can hardly be a doubt that the cure was the result of its use. The extract was fresh from the laboratory of Tilden and Co., and was given for a week in amounts closely approximating half an ounce to an ounce every twenty-four hours; it produced no other sensible effect than that of controlling the spasms and arresting the disease. There was no dizziness, no dimness of sight, no double vision, and no prostration of strength, as I have seen in other patients with other diseases from much smaller doses of the same preparation.

So far as I am aware, this is the only instance, in the records of medicine, of the use of gelseminum in the treatment of tetanus, and the result here is certainly encouraging.

As the gelseminum exerts such powerful control over spasms of the voluntary muscles, I would advise its use in hydrophobia, and I would suggest that it be used hypodermically, whether in tetanus or in hydrophobia.

CASE OF CYSTOCELE: INDUCTION OF PREMATURE LABOUR: OPERATION: RECOVERY.*

By H. E. SPENCER, L.R.C.P. & S.Ed.

I WAS called to attend Mrs. T. on June 23rd, 1882, at 8 A.M. The messenger stated that the patient had been taken in labour at the end of the sixth month of pregnancy, and that in all probability the child would be born before my arrival.

The patient had been four times previously confined, three times of twins, being as it happened one of twins herself. On two of these occasions forceps had been used, on account, it was said, of tumours obstructing the passage. I found the patient apparently on the point of being delivered. Violent expulsive pains came on incessantly, the woman bearing down with all her might, and pulling vigorously at a towel attached to the bed-post. Pains similar to these in character, but less in degree had, however, occurred often within the last few weeks. These violent efforts to expel the supposed foetus had been going on for several hours. On examination, I found a globular mass protruding from the vulva, about the size of the foetal head when crowned, as the nurses say. This turned out to be the anterior wall of the vagina, from the congested surface of which blood was oozing. The uterus showed no signs of labour having commenced. Having called in the aid of my friend, Mr. Weekes, I passed a catheter. Only a little urine, however, escaped, and no relief was given. Pressure above the pubes did not produce any sensation referable to the bladder. The foetal heart was plainly heard.

During the next three days things went on exactly the same way, expulsive pains recurring every few minutes, catheterism and the liberal use of opiates giving scarcely any relief. Objects introduced into the vagina with a view to action as pessaries were immediately expelled. As it appeared that the troubles incident to the vaginal prolapse had greatly increased coincidently with the progress of pregnancy, we decided to induce premature labour. Accordingly on the evening of the 26th, a catheter was inserted between the membranes and uterine wall, pushed up several inches, and left. In twenty-four hours the os was sufficiently dilated to permit the introduction of the hand; and, chloroform having been administered by Mr. Kirsopp, a living female infant, apparently of about six months' development, was extracted by turning. The child lived fourteen hours.

Convalescence went on very satisfactorily, the prolapse and pains being in complete abeyance for a fortnight, when the patient resumed her household duties, suffering only from a slight leucorrhœal discharge. At this period, however, the prolapse returned, causing at first but slight uneasiness, but afterwards almost as great distress as ever, with much dysuria. Accordingly, I resolved that, as soon as her strength allowed it, and the discharge ceased, an operation should be

attempted. By the help of good nourishment, iron, and astringent injections, these conditions were obtained by August 20th. On the 28th the menses appeared, ceasing on the 31st.

On September 4th, the bowels having been previously cleared out, the patient was etherised and placed in the lithotomy position. The bladder was then distended with water, which brought the prolapsed part well within view and reach. A duckbill speculum retracted the perinaeum.

Sitting in front of the patient, I dissected an ellipsoidal piece of mucous membrane two inches long, and one inch broad, from the anterior vaginal wall. One small vessel was tied. The raw edges were brought together by seven sutures of Chinese twist. A catheter was left in, but removed the next day, as it was ill managed and caused irritation. Afterwards a catheter was passed twice a day until the fifth day, when the patient micturated in the knee-elbow position. Vomiting was rather troublesome for the first twenty-four hours. The bowels were at first left to themselves, and did not act until a purgative and enema were given on the sixth day. The pulse and temperature were always normal.

On the seventh day, the patient was chloroformed and again placed in the lithotomy position. The bladder was again injected, but this time the distension was upwards and forwards, a very satisfactory sign as regarded the result of the operation, but not facilitating the removal of the sutures. The speculum was introduced with some difficulty, whereas before the operation it slipped in with ease. Not a trace of irritation showed itself about the wound, which was healing well. The sutures were all removed, and the vagina syringed out. Scarcely any chloroform vomiting followed, and the patient micturated during the afternoon. In the evening, I observed that pressure above the pubes caused a desire to micturate.

November 4th. Upwards of two months have elapsed since the operation, and the patient is in perfect health and free from all discomfort whatever. Indeed, she says, she has not been nearly so well as she is now since her first confinement.

NOVEL METHOD OF COMMITTING SUICIDE.

By M. D. MACLEOD, M.B. Edin.,

Medical Superintendent, East Riding of Yorkshire Asylum, Beverley.

THE report, headed as above, in the number of the BRITISH MEDICAL JOURNAL of July 1st, reminds me of two similar attempts at suffocation, one of which succeeded.

The first case occurred, as far as I can remember, in the Calton Gaol, Edinburgh, and was related to me by the late Dr. Handyside, lecturer on anatomy, Edinburgh School of Medicine. During the dissection of a female subject, it was found that there was firmly impacted in the pharynx, completely occluding the glottis, a carefully made wedge of flannel. Dr. Handyside, I recollect, showed me a drawing of the pharynx, showing the position of the wedge, and a cast of the wedge-shaped pledget of flannel which had been found in the woman's pharynx. The cast showed a strip of flannel, which had been smoothly folded into a cone-shaped mass, and the free end secured by a large pin. I believe Dr. Handyside reported this case at the time, most likely in the *Edinburgh Medical Journal*.

The other case occurred in my own practice, while assistant-medical superintendent of the Cumberland and Westmorland Asylum. The patient was a strong young man, labouring under mania, with active suicidal impulses. At that time he required feeding with the stomach-pump, as he would not take food. On the day in question, he was so violent that he required to be isolated. In the evening he was taken out of his room, so that I might feed him. I remarked that he looked blue and breathed hard, and I was at a loss to account for his state. On opening his mouth with a "Newton's" gag (much against his will), I saw he had pushed something well back into his pharynx. This proved to be a carefully made cone of flannel (a strip of blanket), exactly of the shape of the cast in Dr. Handyside's case. He had doubtless been interrupted as he was pushing the plug down: for there is no doubt, if he had pushed it an inch further, he would have occluded the glottis. No sense of discomfort would have deterred him from effecting his purpose of suicide. Had he succeeded, the true cause of his death might quite possibly have been overlooked, even had an examination of the body been made. It was only by a fortuitous combination of circumstances that the attempt was frustrated.

MEDICAL MAGISTRATE.—The Lord Chancellor has added the name of Dr. Jabez Thomas to the Commission of the Peace for Swansea.

* Read at the Autumn Meeting of the Yorkshire Branch.